Family Psychoeducation

Implementation Resource Kit

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Implementation Tips for Mental Health Program Leaders

The Evidenced-Based Practices Project presents public mental health authorities with a unique opportunity to improve clinical services for adults with severe mental illness. Service system research has evolved to a point where it can identify a cluster of practices that demonstrate a consistent, positive impact on the lives of people who have experienced psychiatric symptoms.

Purpose

This document is designed to help you, as a mental health program leader, understand the contents of the family psychoeducation (FPE) resource kit; and to provide useful strategies for implementing a family psychoeducation program in routine clinical practice. This document draws upon the experiences of other mental health program leaders who have successfully implemented FPE programs, including multi-family psychoeducational groups, in their organizations.

What is family psychoeducation?

Family psychoeducation is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that practitioner, consumer, and family work together to support recovery. Common issues are:

- participation in outpatient programs
- understanding prescribed medication

- drug or alcohol abuse
- symptoms that affect the consumer

Family psychoeducation respects and incorporates individual, family, and cultural perspectives. It engenders hope in place of desperation and demoralization.

Psychoeducation can be used in a single family or multi-family group format, depending on the consumer's and family's wishes, as well as empirical indications. Single family and multi-family group versions will have different outcomes in the long term, but there are similar components. The approach has several phases, each having a specific format:

"Joining" with consumers and their families.

The practitioner establishes a rapport with family members and the consumer, which continues throughout their involvement in treatment. For many practitioners, this requires a shift in traditional roles.

Education about the illness and coping skills.

The practitioner helps families understand that their loved one suffers from a bona fide illness. This relieves families of their guilt and anxiety, so they are able to make major contributions toward recovery.

Problem-solving for difficulties caused by illness and circumstances created by the illness.

Problems are anything that interferes with treatment and recovery, as well as illness and symptom management.

Creating an optimal social environment for recovery from mental illness.

Multi-family groups promote coping skills and ongoing social contact. The family is supported by other families at the educational workshop and ongoing sessions. Families establish connections with others who have similar experiences and in turn gain a broader social network.

What does the evidence say?

Research has shown that, for consumers whose families participate in family psychoeducation programs, relapse rates and rehospitalizations decrease significantly within the first year following hospitalization when compared to groups who use medication, with or without individual psychotherapy. In several studies, relapse decreased in frequency by 50% or more. Especially when carried out in multi-family groups, this approach has provided the psychosocial support consumers need to extend recovery, re-enter the work force, and develop social skills, while their families report a decrease in feeling stressed and isolated. Recent studies have shown employment rate gains of 2 to 4 times baseline levels, especially when combined with supported employment services.

Why work with families?

- To achieve the best possible outcome for the individual with mental illness through collaborative treatment and rehabilitation
- To ease suffering among family members by supporting their efforts to foster their loved one's recovery
- To coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship
- To pay attention to the social, as well as the clinical needs of the consumer
- To listen to families and treat them as equal partners
- To explore family members' expectations and assess a family's strengths and difficulties
- To help resolve family conflict through sensitive response to emotional distress
- To address feelings of loss
- To provide relevant information for consumers and families at appropriate times
- To encourage clear communication among family members
- To provide training for the family in structured problem-solving techniques
- To encourage the family to expand their social support networks
- To be flexible in meeting the needs of the family

Contents of the implementation resource kit

This resource kit includes information that helps the provider effectively lead the family psychoeducation group. Several tools are included, such as information sheets for consumers, families and practitioners, a workbook for learning the basic elements of the approach, fidelity, implementation process and outcome measures, and material for public mental health authorities. These are all intended to support providing services in a way that achieves the same kinds of remarkably improved outcomes that have been repeatedly demonstrated in prior outcome research studies.

Making it happen—building momentum for the implementation of a family psychoeducation program

There is likely to be some apprehension among the organization's personnel about the new program's clinical value, its potential for increased workload for the staff, the need for training that the organization cannot afford, or changes to administrative procedures.

The following tips should alleviate some of these concerns and help the mental health program leader be successful:

Make one person responsible

Implementation of a family psychoeducation program has the greatest chance of success when a sole individual is responsible for leading the change. Success is more likely when that person is the clinical leader for the organization and when the senior administrators are aware and support the programmatic change. In particular, the agency's on-line staff must understand the conceptual framework of the program, be trained in its methodology, see its clinical value, and buy into their new role in the program. In many clinical settings, the leader will need to overcome barriers to implementation. The leader may need to advocate for funding, rally support of the executive director and other key leaders, or bring in consultants/trainers when needed.

Identify and deal with the possible barriers to implementation

When people are made aware of anticipated barriers, they seem to become more energized to overcome those barriers. When these concerns are addressed directly by the leadership they usually dissipate without much cost of time or money. Some of the commonly voiced concerns about family psychoeducation are:

- *There will be an increase in workload*. Studies have shown that over the first year the total workload for a given group of consumers will either be the same as or less than for standard individual therapy and/or case management.
- *Staff has no experience working with families of consumers*. Nearly every practitioner who has adopted this approach and followed the suggested methods has succeeded in achieving the same results as in clinical trials.
- *Consumers do not want their families involved with their treatment*. There are suggested methods for involving consumers in making decisions about including family members in treatment. Once they understand what is involved and how they will benefit, it is extremely rare that a consumer will not give consent and participate.
- *There is no time to learn a new treatment model, regardless of what the research outcomes indicate*. The first implementation will require extra time and effort, but it will be compensated by fewer crises, improved outcomes, and a much greater sense of accomplishment and gratification in one's work.

- *It is difficult to find a colleague to co-lead groups*. It is much more important to include families in the ongoing clinical and recovery work, so start on a single-family basis with a small number of cases and allow colleagues to see the results.
- *Agency administration will not reduce or rearrange caseloads of staff*. It will be the job of the program leader to allow for 3–4 months of reduced case load or relief from intake to set up family psychoeducational services, especially in a multi-family group. It will balance out quickly in improved clinical efficiency.
- *It costs too much*. The organization's leadership will need to ensure that reimbursement covers the slightly greater initial costs, if the program is to be maintained and achieve its potential cost savings.
- *We have to change the procedures already in place*. Yes, a few procedures will need to change, but they are minimal compared to the changes required for assertive community treatment or supported employment (other EBPs). Set up methods for determining which consumers have family available and join with families as soon as possible during an acute episode.

Provide meaningful reasons and incentives

Other key decision-makers in the program—agency CEOs, financial directors, and medical directors—need incentives. They need to understand the cost-benefit ratios to buy into the suggested program change and to support the rest of the process.

Bring in outside speakers to inform and inspire the staff

Engaging a guest speaker who is a well-known expert in the field and a fellow practitioner can advance the credibility of your program. Consumers and their families can also testify about their experiences with family psychoeducation. This is especially effective if their agency is similar to yours.

Connect colleagues

Connecting family practitioners with colleagues who have similar roles in established programs is useful. Case managers tend to listen to other case managers, psychiatrists to psychiatrists.

Frame the adoption of FPE in positive terms

When discussing family psychoeducation with your agency use examples from practitioners who discover how their work suddenly seems more interesting, how they develop a more positive relationship with consumers and families, and how their work load (especially crisis intervention) decreases over time.

Educate practitioners about the research

Include studies and clinical experience that show good results in a variety of cultural groups (such as African-American, Chinese, Southeast Asians, Latino-Americans and others), socioeconomic populations, and geographic settings.

Use a consumer-centered management approach

(See appendix and the Illness Management and Recovery resource kit for more information.) This approach lets practitioners and clinical supervisors measure progress and success by consumer outcomes, rather than by process measures, such as hours of therapy or time in day treatment programs.

Making the change to a family psychoeducation program

Your goal in implementing the new program is to redesign the process of care so that it is easy for practitioners to completely commit to the family psychoeducation model. As a mental health program leader, you need to understand some of the family psychoeducation activities and procedures so that you can support the efforts of your staff.

Meet with families

- Initially, consumers and their families meet with a practitioner at least three separate times to review illness history, warning signs, coping strategies, concerns, and goals for themselves in the program. This is the stage in which rapport and trust are established, as well as the beginning of family education.
- Five to seven consumers and their families participate in one multi-family group. All of these sessions should be reimbursable by insurance. The sessions may last up to two years and often continue longer by request of consumers and their families.
- Five to seven families come together to learn specifics of the illness in a daylong workshop before the first multi-family group or single-family session.
- Some families prefer, and benefit from, continuing in a single-family format.

The program requires co-facilitators

Some agencies report that having three facilitators for multi-family groups is helpful, since it allows staff to rotate through the group, as well as take turns observing one another's techniques. Single-family work is usually done by one practitioner only.

FPE and multi-family groups have a pragmatic, structured, problem-solving format

Experience with group process is not a prerequisite for successful co-facilitation. Staffs interested in learning a new group model often embrace the multi-family group.

Initially co-facilitators take a reduced caseload

Or do not take on new cases. For the first three to four months of family psychoeducation, staff should have no new cases so that the program can get off to a good start. In some instances caseloads are reorganized so that the family psychoeducation cases, especially in multi-family groups, are comprised of participants from more than one clinical caseload, which frees up staff time to take on new cases.

Train staff

Plan to co-facilitate a family psychoeducation training before program implementation. This training would include didactic and experiential information about the techniques for best practice in single or multi-family processes. If needed, it would include didactic and experiential information about the techniques for best practice in culturally diverse settings.

Ensure ongoing supervision for facilitators

This is critical for the program's success. Supervision can be accomplished in person, or long distance through conference calls, telecommunication, or review of videos of the groups in process. Culturally knowledgeable supervisors or consultants are available for the major populations in the United States.

Provide important operational supports

Manage the details of implementation, such as locating a group meeting site, finding funding for refreshments, investigating reimbursement issues, defining documentation and quality improvement criteria, or facilitating a review of the agency's policies and procedures to be sure that they support FPE.

Track outcomes

Outcomes such as decreased relapse rates, decreased medication dosages, reduced family stress, and improved consumer employment and social skills should be tracked for all participants to gauge improvements. The same is true for tracking outcomes for culturally diverse groups, to ensure equity and maximum community benefit.

Maintaining and extending the gains of the family psychoeducation program

To ensure that the organization will permanently adopt the family psychoeducation program and that staff will support it as a routine treatment modality, consider the following activities:

- Visibly recognize staff members who have made family psychoeducation a success in your program.
- Be prepared to train new staff, including clinical supervisors. This means continuously advocating for funding and changes in staffing patterns.
- Incorporate family engagement and education into the intake process, making it a clinical policy and routine procedure.
- Meet with family and consumer advocacy and education organizations to gather their experiences, assessments, and suggestions for improving the program and their role in helping support it.
- Provide family psychoeducation for all individuals and their families experiencing a first episode of a severe mental illness, especially psychosis.
- Find ways to gather and tell family psychoeducation success stories. Devote portions of staff meetings to sharing good news. This could include feedback and anecdotes from consumers, families, and employers.
- Meet with staff and administrators to address problems when they arise whether administrative or clinical in nature.
- Sponsor banquets to celebrate family psychoeducation achievements. Make a big deal out of the achievements and invite physicians and administrators to come to the celebration. Even consider inviting the director of the state's behavioral health division or the governor.
- Use relevant outcome statistics to justify the program's benefits and processes for continuously improving its effectiveness. This will clearly reinforce the consumer-centered outcome goal of the family psychoeducation program.

For more information

Information about family psychoeducation, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

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Appendix: Co-facilitator job description

- Minimum college degree, with some clinical experience.
- Master's level degree is preferred.
- Interest in learning a non-process group intervention model that includes families.
- Interest in working with families and with individuals with serious mental illness.
- Background experience in family therapy is preferred.
- Willingness to adopt a new conceptual framework and practice paradigm.